

**CONFIDENTIAL COMMUNICATION REQUEST**

File Number: \_\_\_\_\_

You may request the Department of Health Services to contact you at another address or telephone number, other than what is currently in your *Program Name* records, or by a different method (such as only by mail or only by telephone). To request this, mail this completed form to:

*(This section to be completed by the Program before sending to beneficiaries)*

*Program Name*  
*Return Address*  
*Phone number*

INDIVIDUAL INFORMATION				
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
CURRENT ADDRESS:		CITY/STATE:		ZIP CODE:
BENEFICIARY ID NUMBER:		DATE OF BIRTH:		
CURRENT DAYTIME TELEPHONE NUMBER: (     )	CURRENT EVENING TELEPHONE NUMBER: (     )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:	
<b>I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES CONTACT ME AT A DIFFERENT ADDRESS AND/OR A DIFFERENT TELEPHONE NUMBER THAN WHAT IS LISTED IN MY <i>PROGRAM NAME</i> RECORDS BECAUSE CONTACTING ME AT MY CURRENT ADDRESS AND/OR TELEPHONE NUMBER IS A SAFETY ISSUE FOR ME.</b>				
ALTERNATE STREET ADDRESS OR POST OFFICE BOX TO CONTACT ME				
CITY, STATE			ZIP CODE	
ALTERNATE TELEPHONE NUMBER TO CONTACT ME (     )				
<b>I MAY ALSO REQUEST THE DEPARTMENT OF HEALTH SERVICES TO LIMIT THE WAY IT CONTACTS ME.</b>				
I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES CONTACT ME <input type="checkbox"/> ONLY BY TELEPHONE <input type="checkbox"/> ONLY BY MAIL (PLEASE CHECK ONE)				

## IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE \_\_\_\_\_ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER \_\_\_\_\_

**I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.**

BENEFICIARY SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.)**

NOTARIZED BY \_\_\_\_\_ ON \_\_\_\_\_  
(DATE)

NOTARY PUBLIC NUMBER \_\_\_\_\_

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION \_\_\_\_\_ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

**NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.**